

01529

CERTIFICATE OF DEATH

01526

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BERLIN</u>		c. LENGTH OF STAY IN 1b <u>231</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>O.C. BLVD R 2</u>	
3. NAME OF DECEASED (Type or print) <u>GRACE JANIE CROPPER</u>		4. DATE OF DEATH Month <u>JAN</u> Day <u>23</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 15, 1896</u>
9. AGE (In years lost birthday) <u>70</u> yrs.		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>STONVHILL MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JAMES ELMER STOCKLEY</u>		14. MOTHER'S MAIDEN NAME <u>ANNA MAE COULBOURN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>217-36-0083</u>	
17. INFORMANT <u>Mr. SEWELL CROPPER</u>		Address <u>BERLIN MD</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO <u>myocarditis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>1st pertension</u> (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1-1-</u> , 19 <u>67</u> to <u>1-23</u> , 19 <u>67</u> , that (I) (we) lost saw the deceased alive on <u>1-22-</u> <u>1967</u> , and that death occurred at <u>6 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Clifford E. Schott</u>		22b. DATE SIGNED <u>1-26-1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Clifford E. Schott M.D.</u>		22d. ADDRESS <u>Berlin, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>1/26/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Buckingham</u>		23d. LOCATION (City or Town) (County) (State) <u>Berlin Wor MD</u>	
24. FUNERAL DIRECTOR <u>Anna A. Burdage Berlin Md</u>		25a. REC'D BY REGISTRAR <u>JAN 20 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please, remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

01523

CERTIFICATE OF MARRIAGE

01524

1916

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
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01530
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Items 2, 9 Film 6385 1/31/67 mh-
01527

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY WORCESTER b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BERLIN c. LENGTH OF STAY IN Tb 23-1		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WORCESTER c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BERLIN	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) BERLIN NURSING HOME		d. STREET ADDRESS NNNN/14/11 West St.	
3. NAME OF DECEASED (Type or print) First Middle Last BERTHA E. HANLEY		4. DATE OF DEATH Month Day Year JAN 24 1967	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	8. DATE OF BIRTH Oct. 7, 1880
9. AGE (In years last birthday) 86 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. 00 00 00 00	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HUSBAND		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (County & State, or foreign country) BERLIN MD		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM EDWARD BAKER		14. MOTHER'S MAIDEN NAME MARY JARMON	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO NO		16. SOCIAL SECURITY NO. NO	
17. INFORMANT Nursing Home Record		Address Berlin Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X Chronic Bright's & Uremic Poisoning DUE TO (b) Chr. Myocarditis DUE TO (c) Hypertension, arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 3 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 10 - , 1967, to Jan 24 , 1967, that (I) (we) last saw the deceased alive on Jan 24 , 1967, and that death occurred at 2:00 PM , from causes and on the date stated above.			
22a. SIGNATURE Chas R Law		22b. DATE SIGNED 1-26-67	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS Berlin Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/27/67	
23c. NAME OF CEMETERY OR CREMATORY EVERGREEN		23d. LOCATION (City or Town) (County) (State) BERLIN WOR. MD	
24. FUNERAL DIRECTOR Anna A. Burbage		25a. REC'D BY REGISTRAR DATE JAN 27 1967	
ADDRESS Berlin Md		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
01531					01528				
1. PLACE OF DEATH a. COUNTY Worcester MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Pocomoke City			c. LENGTH OF STAY IN 1b 50 years		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Pocomoke City <i>23.1</i>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Clarke Avenue					d. STREET ADDRESS Clarke Avenue			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOSEPH Middle HARLAN Last HENDERSON					4. DATE OF DEATH Month January Day 7 Year 1967				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 21, 1906		9. AGE (In years last birthday) 60 yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanical Engineer			10b. KIND OF BUSINESS OR INDUSTRY Food Processing			11. BIRTHPLACE (County & State, or foreign country) Somerset County, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Austin Charles Henderson					14. MOTHER'S MAIDEN NAME Sallie Ruark				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. --		17. INFORMANT Mrs Irene Henderson			Address Pocomoke City, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO (b) Arteriosclerotic Heart Disease DUE TO (c) unknown Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH 1 hr				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized Arteriosclerosis and Vasculopathy					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from Jan. 7, 1967 to Jan. 7, 1967 , that (I) (we) last saw the deceased alive on Jan. 7, 1967 , and that death occurred at 7:15 PM , from the causes and on the date stated above.									
22a. SIGNATURE Charles W. Trader					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED Jan. 9, 1967	
22c. PHYSICIAN'S NAME (Type) Charles W. Trader, M.D.					22d. ADDRESS 302 Market, Pocomoke City, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 1-11-1967		23c. NAME OF CEMETERY OR CREMATION First Baptist		23d. LOCATION (City, town or county) (State) Pocomoke City, Maryland		
24. FUNERAL DIRECTOR Robert H. Watson					ADDRESS Pocomoke City, Md.		25a. REC'D BY REGISTRAR JAN 12 1967		25b. REGISTRAR'S SIGNATURE Charles Judge

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Charles Yarnall

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
01532					01529				
1. PLACE OF DEATH a. COUNTY <u>WORCESTER</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BERLIN</u>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BERLIN</u>			23.1	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					d. STREET ADDRESS <u>WASHINGTON</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>KENDALL</u> Middle <u>P.</u> Last <u>JARVIS SR.</u>					4. DATE OF DEATH Month <u>JAN</u> Day <u>22</u> Year <u>1967</u>				
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>OCT. 31, 1877</u>	9. AGE (in years last birthday) <u>89</u> yrs.	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>		
1Da. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MERCHANT</u>		1Db. KIND OF BUSINESS OR INDUSTRY <u>OWN STORE</u>		11. BIRTHPLACE (County & State, or foreign country) <u>BERLIN MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>HARRY L. JARVIS</u>				14. MOTHER'S MAIDEN NAME <u>MARGARET PATTEY</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>220-46-7955</u>		17. INFORMANT <u>MRS. K. P. JARVIS SR</u> Address <u>BERLIN MD</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Diabetes Mellitus</u> 260X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____								INTERVAL BETWEEN ONSET AND DEATH <u>57 Years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Degenerative Cardiovascular Disease</u>								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that (I) <u>this hospital</u> attended the deceased from <u>2/14/61</u> , 19____, to <u>1/20/67</u> , 19____, that (I) (we) last saw the deceased alive on <u>1/20/67</u> , 19____, and that death occurred at <u>12N</u> M, from the causes and on the date stated above.									
22a. SIGNATURE <u>Ivory U. Sully, Jr.</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>1/23/67</u>			
22c. PHYSICIAN'S NAME (Type) <u>Ivory U. Sully, Jr., MD</u>				22d. ADDRESS <u>P. O. Box 126, Berlin, Md. 21811</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>1/25/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ST. PAUL'S</u>		23d. LOCATION (City, town or county) <u>BERLIN</u> (State) <u>MD</u>			
24. FUNERAL DIRECTOR <u>Anna A. Burdige</u> ADDRESS <u>Berlin Md</u>				25a. REC'D BY REGISTRAR <u>JAN 25 1967</u> DATE		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

MEDICAL CERTIFICATION

01232

01232

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
01533					01530				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)				
a. COUNTY Worcester MARYLAND					a. STATE Maryland b. COUNTY Worcester				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)				
Rural-Pocomoke City Life					Rural-Pocomoke City 23-1				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					d. STREET ADDRESS				
R.F.D. 2					R.F.D. 2				
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH				
First Middle Last EDWARD --- MASON					Month Day Year January 30 19 67				
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)	
Male		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Oct. 17, 1896		70 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Farmer				Farming		Worcester County, Maryland		U.S.A.	
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME				
Julius Mason					Arenthia Disharoon				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)					16. SOCIAL SECURITY NO.		17. INFORMANT Address		
Yes W.W. 1					216-18-2073		Mrs Lela Mason, Pocomoke City, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of Prostate G									
(c) Metastases									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19									
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>									
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)									
20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from March 1966 to Jan 30, 1967, that (I) last saw the deceased alive on Jan 30, 1967, and that death occurred at 9:30 PM from the causes and on the date stated above.									
22a. SIGNATURE Donald F. Fletcher, M.D.									
22b. DATE SIGNED 1/30/67									
22c. PHYSICIAN'S NAME (Type) Donald F. Fletcher, M.D.									
22d. ADDRESS Horsey, Virginia									
23a. BURIAL, CREMATION, REMOVAL (Specify)									
Burial									
23b. DATE THEREOF 2-2-1967									
23c. NAME OF CEMETERY First Baptist									
23d. LOCATION (City, town or county) (State) Pocomoke City, Maryland									
24. FUNERAL DIRECTOR ADDRESS									
Robert H. Watson Pocomoke City, Md.									
25a. REC'D BY REGISTRAR DATE FEB 3 1967									
25b. REGISTRAR'S SIGNATURE Charles Judge									

012-16

1133

Exhibit 1 of 10
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Exhibit 6 of 10
Exhibit 7 of 10
Exhibit 8 of 10
Exhibit 9 of 10
Exhibit 10 of 10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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VR A15 (4)
20M 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
01534					01531				
1. PLACE OF DEATH a. COUNTY Worcester b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural Whaleyville c. LENGTH OF STAY IN 1b app. 50 yrs. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural Whaleyville d. STREET ADDRESS 23.1 e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Harry F. McCabe			4. DATE OF DEATH Jan. 30, 1967						
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 3, 1893		9. AGE (In years last birthday) 73 yrs. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer			10b. KIND OF BUSINESS OR INDUSTRY farming		11. BIRTHPLACE (County & State, or foreign country) Sussex County, Dela.			12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Lemuel McCabe					14. MOTHER'S MAIDEN NAME Lillian Evans				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no			16. SOCIAL SECURITY NO. 213-16-8557		17. INFORMANT Mary E. McCabe Address Whaleyville, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Apoplexy 334X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) Hypertension DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 1-15-50 to 1-30, 1967 that (I) (we) last saw the deceased alive on 1-29-67 , and that death occurred at 11:30 AM , from the causes and on the date stated above.									
22a. SIGNATURE Clifford E. Schott								22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Clifford E. Schott M.D.								22d. ADDRESS Berlin Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 2/2/67		23c. NAME OF CEMETERY OR CREMATORY Ebenezer Cem.			23d. LOCATION (City, town or county) (State) Worcester, Md.	
24. FUNERAL DIRECTOR Richard T. Watson ADDRESS Selbyville, Dela.					25a. REC'D BY REGISTRAR FEB 3 1967		25b. REGISTRAR'S SIGNATURE Charles J...		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
01535					CERTIFICATE OF DEATH					01532				
1. PLACE OF DEATH a. COUNTY Worcester b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bishopville Rural c. LENGTH OF STAY IN 1b Life d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bishopville Md. Rural 23.1 d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) Albert Z. Purnell			First Z.		Middle Purnell		Last		4. DATE OF DEATH Month January Day 6 Year 1967					
5. SEX Male		6. COLOR OR RACE colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Apr. 26, 1907		9. AGE (in years last birthday) 59 yrs.		IF UNDER 1 YEAR Months Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY Chicken Plant		11. BIRTHPLACE (County & State, or foreign country) Worcester Co. Md.			12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME John J. Purnell					14. MOTHER'S MAIDEN NAME Annie Kate Purnell									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. 212-14-4244		17. INFORMANT Margie Pernell			Address Bishopville, Md.						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cardio-vascular Disease DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH Immediate 7 1/2 Yrs.														
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arthritis										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)										
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) 19		(County) 19		(State) 19			
21. I certify that (I) was not attended the deceased from 1/31/59 , 19 59 , to 12/20/66 , 19 66 , that (I) we saw the deceased alive on 12/20/66 , 19 66 , and that death occurred at 3 A M, from the causes and on the date stated above.														
22a. SIGNATURE Ivory U. Sully, Jr.								ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 1/7/67				
22c. PHYSICIAN'S NAME (Type) Ivory U. Sully, Jr., MD, Berlin, Md., 21811								22d. ADDRESS Berlin, Md., 21811						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 9, 1967		23c. NAME OF CEMETERY OR CREMATORY Showell Cemetery			23d. LOCATION (City, town or county) Showell Md.							
24. FUNERAL DIRECTOR Richard T. Watson				ADDRESS Selbyville, Del.		25a. REC'D BY REGISTRAR JAN 11 1967		25b. REGISTRAR'S SIGNATURE Charles Judge						

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01536

CERTIFICATE OF DEATH

01533

1. PLACE OF DEATH a. COUNTY Worcester b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Snow Hill		c. LENGTH OF STAY IN 15 23.1		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 207 Shipyard Alley		d. STREET ADDRESS 207 Shipyard Alley		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) DOROTHY First Middle Last - STANLEY		4. DATE OF DEATH Month Day Year January 10 1967			
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Mar. 1, 1925		9. AGE (In years lost birthday) yrs. 41
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Garland Stanley			
14. MOTHER'S MAIDEN NAME Unknown		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			
16. SOCIAL SECURITY NO. None		17. INFORMANT James Mears, Snow Hill, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 581.1 IMMEDIATE CAUSE (a) Gastrointestinal Hemorrhage DUE TO (b) Esophageal Varices DUE TO (c) Cirrhosis of Liver (Laennec) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 0021					INTERVAL BETWEEN ONSET AND DEATH 3 hrs years years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus; Pulmonary Tbc					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from Jan 9, 1967 to Jan 9, 1967 that (I) (we) last saw the deceased alive on Jan 9, 1967 , and that death occurred at Jan 9, 1967 M, from causes and on the date stated above.			
22a. SIGNATURE DAVID A. BAEAT		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) DAVID A. BAEAT		22d. ADDRESS Snow Hill, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan 15, 1967		23c. NAME OF CEMETERY OR CREMATORY Mt. Zion Baptist	
23d. LOCATION (City or Town) (County) (State) Snow Hill, Md.		25a. REC'D BY REGISTRAR JAN 16 1967			
24. FUNERAL DIRECTOR Charles Judge		ADDRESS Snow Hill, Maryland		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

01238

OFFICE OF DEATH

01238

NAME OF DECEASED		DATE OF DEATH	
LAST NAME		FIRST NAME	
MIDDLE NAME		AGE	
SEX		RACE	
RELIGION		EDUCATION	
OCCUPATION		MARRIED	
SPOUSE'S NAME		SPOUSE'S DATE OF BIRTH	
SPOUSE'S PLACE OF BIRTH		SPOUSE'S OCCUPATION	
SPOUSE'S RELIGION		SPOUSE'S EDUCATION	
SPOUSE'S MARRIAGE DATE		SPOUSE'S MARRIAGE PLACE	
SPOUSE'S MARRIAGE TYPE		SPOUSE'S MARRIAGE OFFICIAL	
SPOUSE'S MARRIAGE WITNESSES		SPOUSE'S MARRIAGE VOUCHER	
SPOUSE'S MARRIAGE CERTIFICATE		SPOUSE'S MARRIAGE REGISTRATION	
SPOUSE'S MARRIAGE RECORD		SPOUSE'S MARRIAGE INDEX	
SPOUSE'S MARRIAGE SEARCH		SPOUSE'S MARRIAGE SUMMARY	
SPOUSE'S MARRIAGE ANALYSIS		SPOUSE'S MARRIAGE EVALUATION	
SPOUSE'S MARRIAGE RECOMMENDATION		SPOUSE'S MARRIAGE CONCLUSION	
SPOUSE'S MARRIAGE FINAL REPORT		SPOUSE'S MARRIAGE FINAL SUMMARY	
SPOUSE'S MARRIAGE FINAL ANALYSIS		SPOUSE'S MARRIAGE FINAL EVALUATION	
SPOUSE'S MARRIAGE FINAL RECOMMENDATION		SPOUSE'S MARRIAGE FINAL CONCLUSION	
SPOUSE'S MARRIAGE FINAL REPORT		SPOUSE'S MARRIAGE FINAL SUMMARY	
SPOUSE'S MARRIAGE FINAL ANALYSIS		SPOUSE'S MARRIAGE FINAL EVALUATION	
SPOUSE'S MARRIAGE FINAL RECOMMENDATION		SPOUSE'S MARRIAGE FINAL CONCLUSION	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
01537					01534				
1. PLACE OF DEATH a. COUNTY Worcester MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural-Stockton			c. LENGTH OF STAY IN 1b 16 years		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural-Stockton 23.1				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) R.F.D. 1					d. STREET ADDRESS R.F.D. 1			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JOHN WILLIAM TAYLOR			First Middle Last		4. DATE OF DEATH January 11, 1967		Month Day Year		
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 9, 1887		9. AGE (In years last birthday) 79 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer				10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (County & State, or foreign country) Accomack County, Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME -unknown-					14. MOTHER'S MAIDEN NAME Ellen Phillips				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 219-05-9366		17. INFORMANT Mrs Mildred Welch, Stockton, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4/20.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from Sept 1966 to Jan 1967 that (I) (we) last saw the deceased alive on Jan 12 1967 and that death occurred at 2 AM, from the causes and on the date stated above. 22a. SIGNATURE David Rafat 22c. PHYSICIAN'S NAME (Type) DAVID RAFAT 22b. DATE SIGNED 1-13-67 22d. ADDRESS Snow Hill Md. 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 1-15-1967 23c. NAME OF CEMETERY OR CREMATORIUM Wattsville Methodist 23d. LOCATION (City, town or county) (State) Wattsville, Virginia 24. FUNERAL DIRECTOR Robert H. Watson 25a. REC'D BY REGISTRAR JAN 16 1967 25b. REGISTRAR'S SIGNATURE Charles Judge									

05210

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

(M)

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01538

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01535

1. PLACE OF DEATH a. COUNTY Worcester MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke City				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke City 23-1			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 221 Cedar Street				d. STREET ADDRESS 221 Cedar Street			
3. NAME OF DECEASED (Type or print) First MIDDLE Last ROBERT LUTHER WALKER, SR.				4. DATE OF DEATH Month Day Year January 2 1967			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 27, 1881		9. AGE (In years last birthday) 85 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Building		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas A. Walker				14. MOTHER'S MAIDEN NAME Ida Bowdle			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213-05-2100		17. INFORMANT Mrs Myrtle Revell, Pocomoke City, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 976X BULLET WOUND - LEFT CHEST Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) (SELF-INFLICTED) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH MINUTES
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) PERIPHERAL VASCULAR DISEASE							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) SHOT SELF WITH OWN RIFLE WHILE SEATED ON BEDSIDE					
20c. TIME OF INJURY Month, Day, Year 2 Hour 1-2-67 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Pocomoke Worc. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Robert C. LaMar, M.D.				22. DATE SIGNED 1-2-67			
EXAMINER'S NAME (Type) Robert C. LaMar, M.D.				104 Bay Street, Snow Hill, Md. Address (Street, city, town or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-4-1967		23c. NAME OF CEMETERY Bethany Methodist		23d. LOCATION (City, town or county) (State) Pocomoke City, Maryland	
24. FUNERAL DIRECTOR Robert H. Watson				25a. REC'D BY REGISTRAR JAN 6 1967			
				25b. REGISTRAR'S SIGNATURE Charles Judge			

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01539

CERTIFICATE OF DEATH

01536

1. PLACE OF DEATH a. COUNTY <u>Worcester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ocean City</u>		c. LENGTH OF STAY IN lb <u>23.1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>202 N 1ST ST</u>	
3. NAME OF DECEASED (Type or print) <u>Herman Clifford Wooten</u>		4. DATE OF DEATH Month <u>Jan</u> Day <u>21</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/22/05</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Contractor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Building</u>	9. AGE (In years last birthday) <u>61</u> Yrs.
11. BIRTHPLACE (County & State, or foreign country) <u>Berlin Md</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>Lorenzo Wooten</u>		14. MOTHER'S MAIDEN NAME <u>Mary Elizabeth Clark</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes W. War</u>		16. SOCIAL SECURITY NO. <u>219-05-8919</u>	
17. INFORMANT <u>Mrs. H.C. Wooten</u>		Address <u>Ocean City, Md</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Pulmonary Emphysema</u> DUE TO (b) <u>Pulmonary Tuberculosis</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>102.1</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs</u> <u>4 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Cardiovascular Disease</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>4/19</u> , 19 <u>60</u> , to <u>1/20</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>1/20/67</u> , and that death occurred at <u>1/20/67</u> M, from causes on and on the date stated above.			
22a. SIGNATURE <u>Ivory V. Sully, Jr. M.D.</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>1/23/67</u>
22c. PHYSICIAN'S NAME (Type) <u>Ivory V. Sully, Jr. M.D.</u>		22d. ADDRESS <u>P.O. Box 126, Berlin, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>1/24/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Sunset Memorial</u>	23d. LOCATION (City or Town) (County) (State) <u>Berlin Worcester Md</u>
24. FUNERAL DIRECTOR <u>Amos A. Burbage, Berlin Md.</u>		25a. REC'D BY REGISTRAR DATE <u>JAN 25 1967</u>	25b. REGISTRAR'S SIGNATURE <u>J. Charles Jones</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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